COPPIN STATE UNIVERSITY

DIVISION OF STUDENT LIFE / AREA OF STUDENT DEVELOPMENT

HEALTH PROMOTION / WELLNESS CENTER

Confidential
Health History

PLEASE PRINT OR TYPE:

I plan to participate in Intercollegiate Sports. Yes ___ No___

Last Name | First Name | Middle

Soc. Sec# | Sex | F

Home Address | City or Town

Home Telephone | Work Telephone

S ☐ M ☐ D ☐ W ☐
Marital Status

Month & Year Entering Coppin

Date of Birth

Emergency Contact Name | Phone Number

Address | Number

Health Insurance Information: (The University requires all full time students to have health insurance. You may purchase a policy through the University)

If you have any type of health insurance or HMO specify details.

Company or Organization Name

Address

Member or Group Number

Expiration Date

Medical History - please indicate problems you have now or may have had in the past.

Weight: _____
Height: _____

Please Circle One

Acne	Yes	No
Alcohol problem	Yes	No
Allergies	Yes	No
Sickle Cell	Yes	No
Asthma	Yes	No
Back problems	Yes	No
Bladder Infections	Yes	No
Bleeding Trait	Yes	No
Broken Bones	Yes	No
Breast Disease	Yes	No
Bronchitis	Yes	No
Cancer	Yes	No
Colitis	Yes	No
Concussion	Yes	No
Condyloma (genital warts)	Yes	No
Depression	Yes	No
Diabetes	Yes	No
Diarrhea	Yes	No
Dizziness	Yes	No
Drug Dependency	Yes	No
Dyslexia	Yes	No
Ear Problem	Yes	No
Pneumonia	Yes	No
Specify _____		
Eczema	Yes	No
Emotional Illness	Yes	No
Gallbladder Problems	Yes	No
Gonorrhea	Yes	No
Gout	Yes	No
Hay Fever	Yes	No
Hearing Loss	Yes	No
Heart Problems:	Yes	No
Chest Pain	Yes	No
Murmurs	Yes	No
Rheumatic Disease	Yes	No
Other _____		
Shortness of Breath	Yes	No
Hernia	Yes	No
Herpes (Genital)	Yes	No
High Blood Pressure	Yes	No
HW	Yes	No
Hypoglycemia (low sugar)	Yes	No
Infectious Mono	Yes	No
Joint Disease	Yes	No
Kidney Problems	Yes	No
Knee Injury	Yes	No
Migraines	Yes	No
Nervous Stomach	Yes	No
Urethritis (non-gonococcal)	Yes	No
Obesity	Yes	No
Peptic Ulcer (gastric or duodenal)	Yes	No
Rheumatic Fever	Yes	No
Seizures	Yes	No
Sinus Problem	Yes	No
Suicide Attempt	Yes	No
Syphilis	Yes	No
Sexually Transmitted Disease	Yes	No

MALES

Prostate Problems	Yes	No
Lump in Testicles	Yes	No

FEMALES

Irregular Period	Yes	No
Severe Cramps	Yes	No
Pregnancy	Yes	No
Cystic Breasts	Yes	No

1. Surgery: i.e. Appendectomy, tonsillectomy, hernia repair, etc. (List below)
   _____
   _____
2. List below all drugs, including over the counter, birth control, laxatives, and sleeping medication currently being used:
   _____
   _____
3. List below all allergies to medicine, food, insect stings, or other:
   _____
   _____
4. List any disabilities which requires assistance:
   _____
   _____

Date Received by Wellness Center Staff

FAMILY HISTORY

MOTHER'S NAME (please print) Age

HEALTH STATUS

Good Fair Poor

OCCUPATION

CAUSE OF DEATH

FATHER'S NAME Age

HEALTH STATUS

Good Fair Poor

OCCUPATION

CAUSE OF DEATH

Number of Brothers _____ Sisters _____

Have *any of* your blood relatives ever had *any of* the following? If you do not know, discuss with a relative.

		Relationship			Relationship
Arthritis	Yes No		Hay fever	Yes No	
Asthma	Yes No		Heart Attack	Yes No	
Alcoholism/Addiction	Yes No		High Cholesterol	Yes No	
Blood Pressure	Yes No		Hyperlipidemia	Yes No	
Bleeding Disorder	Yes No		Kidney Disease	Yes No	
Cancer	Yes No		Stroke	Yes No	
Convulsions	Yes No		Suicide	Yes No	
Diabetes	Yes No		Stomach Disease	Yes No	
Epilepsy	Yes No		Tuberculosis	Yes No	

Do you have any questions or concerns in regard to health, family history, or family matters, which you need to discuss with a member of the Health/ Wellness Center?

_____

_____

_____

This form has been completed truthfully to the best of my ability.

_____

_____

_____

Student Signature: _____ Date: _____

Parental Permit:
The law requires that parental permission be obtained for minors. The consent form should be signed by parents so that procedures of emergency precautions may be carried out promptly with no unnecessary delays. No procedures will be performed, except in extreme emergency, without parents being contacted and fully informed.

I give permission for diagnostic and therapeutic procedures as may be deemed necessary for my son/daughter and also to present information concerning his/her medical condition to other responsible College Officials when deemed desirable.

Signed: _____

PHYSICAL EXAMINATION

TO THE EXAMINING PHYSICIAN: Please review the student's history and complete the physical exam. This student has been accepted. The information supplied will be used only as a background for providing healthcare. The information is strictly for the use of the Health Services and will not be released without student consent. Please mail immediately.

Height	Weight		Endocrine	Skin
Eyes	Vision (R) (L)		Correction (R) (L)	
Ears		Drums (R) (L)		Hearing (R) (L)
Nose		Septum		Sinuses
Oropharynx		Tonsils		Teeth
Neck		Cervical Glands		**Thyroid**
Chest		Breasts		Lungs
Heart	Rate	**Rhythm**	Murmurs	Blood Pressure
Abdomen	Liver	Spleen	Kidney	Hernia
Skeletal	Spine	Joints	Feet	
Neuro		Reflexes		Emotional

Laboratory Urinalysis

Sugar _____ Protein _____ Hematuria _____ SG

Optional HCT _____ Chol _____

IMMUNIZATION HISTORY

NOTE: ALL residential students of Coppin State University must submit complete records to the Helene Fuld School of Nursing Community Health Clinic by deadline dates (August and November). If born before 1957, you are considered immune to M-M-R (measles, mumps, and rubella). If born AFTER 1957, you should have a re-vaccination for MMR before admission. Titers are required for MMR's and Hepatitis by clinical agencies for nursing students.

IMMUNIZATION DATES

1. MMR: FIRST *SHOT:* SECOND *SHOT:* To be valid, *2nd shot must* **be** *after 1980.*

Measles _____ _____

Mumps _____ _____

Rubella _____ _____
(German Measles)

2. DTP

Diphtheria, Tetanus, Pertussis _____

_____ Childhood Series

TD Booster _____ Required within past 10 years.

3. TB Test or Chest X-Ray _____
Within the past year.

If PPD is positive, X-ray required _____

4. Polio

Childhood Series/Booster _____

5. Hepatitis B: _____ Mandatory for Clinical Nursing Students: ___ Titers
1st 2nd Final

6. Varicella: _____ Meningitis: _____

Physician Signature: _____ Date: _____
And Physician Stamp